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Supreme Court, U.S.
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No.

IN THE

Supreme Court of the United States

OCTOBER TERM, 1988

JOSEPH V. JULIANO,
Petitioner,
vs.
COMMERCIAL LIFE INSURANCE COMPANY
and AUTOMATIC DATA PROCESSING, INC.,
Respondents.

ON PETITION FOR WRIT OF CERTIORARI
TO THE CALIFORNIA SUPREME COURT

PETITION FOR WRIT OF CERTIORARI

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QUESTION PRESENTED

Does this Court's opinion in *Pilot Life Ins. Co. v. Dedeaux*, 107 S.Ct. 3085 (1987) require federal preemption of the California Insurance Code regulating unfair insurance company practices when ERISA saves from preemption laws which regulate insurance?

LIST OF PARTIES

The parties to the proceedings below were petitioner, JOSEPH V. JULIANO real party in interest, and respondents, COMMERCIAL LIFE INSURANCE COMPANY and AUTOMATIC DATA PROCESSING, INC., collectively referred to as COMMERCIAL LIFE.

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No. _____

In The

SUPREME COURT OF THE UNITED STATES

October Term, 1988

JOSEPH V. JULIANO,

Petitioner,

vs.

COMMERCIAL LIFE INSURANCE COMPANY and AUTOMATIC DATA PROCESSING, INC.,

Respondents.

PETITION FOR WRIT OF CERTIORARI

Petitioner, JOSEPH JULIANO, respectfully prays that a writ of certiorari issue to review the judgment and opinion of the California Supreme Court entered in the above-entitled proceeding on December 15, 1988.

OPINIONS BELOW

The opinion of the California Supreme Court in *Commercial Life Ins. Co., et al. v. Superior Court of San Diego County* (Joseph V. Juliano, Real Party in Interest) has not yet been reported in the official reports. The decision as will be published is reprinted as Appendix "B," attached hereto. The Alternative Writ of Mandate is attached as Appendix "A."

The opinion of the District Court of Appeal denying the Petition for Writ of Mandate filed by respondents is not printed in the official reports and is attached as Appendix "C."

The Superior Court's Minute Order is attached as Appendix "D."

JURISDICTION

Petitioner originally brought this action in the Superior Court of California, County of San Diego, on May 24, 1985. Respondents answered and filed a Motion for Judgment on the Pleadings. The trial court denied respondents' motion as to one cause of action. Respondents' Petition for Writ of Mandate to compel the trial court to enter judgment on the pleadings was denied on November 3, 1987. The California Supreme Court granted respondents' Petition for Review and issued its opinion on December 15, 1988. The decision issued a peremptory Writ of Mandate directing the Superior Court of San Diego County to vacate its order denying defendants' Motion for Judgment on the Pleadings as to plaintiff's cause of action for breach of statutory duties under California Insurance Code §790.03(h) and to enter a new order finding preemption under 29 U.S.C. §1001, *et seq.*

The jurisdiction of this court to review the judgment of the California Supreme Court is based upon the federal question presented by the California Supreme Court's interpretation of the Employee Retirement Income Security Act of 1974 (29 U.S.C. §1001, *et seq.*)

STATUTES INVOLVED

The principal statutes involved are: The Employee Retirement Income Security Act of 1974 (ERISA) 29 U.S.C. §1001, *et seq.* Pertinent portions of this statute are quoted in the California Supreme Court opinion attached as Appendix "B." The California Insurance Code §790.03(h) (Wests 1982) quoted in fn. 2 of page B-2 of

Appendix "B." The McCarran-Ferguson Act, 15 U.S.C. §§1012, *et seq.*, partially quoted *infra* at pp. B-14, B-15

STATEMENT OF THE CASE

Petitioner JOSEPH JULIANO suffered from diabetes and, eventually, from diabetic retinopathy.[1] JULIANO and JULIANO's doctor obtained authorization to perform surgery from COMMERCIAL LIFE and COMMERCIAL LIFE confirmed that JULIANO's claims were covered under an insurance policy issued by COMMERCIAL LIFE. COMMERCIAL LIFE paid some medical bills and then arbitrarily refused to pay additional medical bills asserting that the diabetic retinopathy was a preexisting condition and therefore excluded from coverage.

COMMERCIAL LIFE's refusal to pay JULIANO's claim for medical treatment was in violation of standards set forth in California Insurance Code §790.03(h).

JULIANO's employer was the policyholder of a group insurance policy issued by COMMERCIAL LIFE INSURANCE COMPANY and administrated by AUTOMATIC DATA PROCESSING, INC.

JULIANO sued COMMERCIAL LIFE in state court. The Complaint alleged eight common law causes of action for insurance bad faith and a single statutory cause of action for violation of California Insurance Code §790.03(h).

Upon Motion for Judgment on the Pleadings, all of JULIANO's common law causes of action were ruled to

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[1] Because this case arose following judgment on the pleadings, the facts as alleged in the Complaint are deemed true. *Colberg, Inc. v. State Dept. of Public Works*, 67 Cal.2d 408, 412 (1967). Some of the pertinent facts alleged are not set forth in the Supreme Court opinion.

be preempted by the Employee Retirement Income Security Act (ERISA). The trial court found JULIANO's claim for violation of the California Insurance Code was not preempted. COMMERCIAL LIFE filed a Petition for Writ of Mandate in the court of appeal. The court of appeal summarily denied the Petition. The California Supreme Court granted review and issued an alternative writ. Upon submission, the California Supreme Court issued a Peremptory Writ of Mandate to the Superior Court of San Diego County ordering it to vacate its order denying COMMERCIAL LIFE's Motion for Judgment on the Pleadings and to enter an order consistent with a finding that JULIANO's cause of action for breach of statutory duties set forth in the California Insurance Code was preempted by ERISA.

A. Purposes Underlying ERISA

ERISA was never intended to regulate insurance. ERISA was never intended to affect the rights of states to regulate insurance. Congress enacted ERISA to address particular social problems. Of specific concern, was the possibility of widespread abuse by the fiduciaries of employee pension plans. Underfunded pension plans, irresponsible fiduciaries, and a generally depressed economic environment contributed to the likelihood that many employees might be unable to obtain pension benefits even as the entire work force aged and the Social Security system became more and more precarious.[2]

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[2] *See generally*, 29 U.S.C. §1144; H.R. Rep. No. 807, 93d Cong., 2d. Sess., reprinted in 1974 *U.S. Code Cong. & Admin. News* 4670, 4678-9, 4680 ("House Report No. 807"); S. Rep. No. 383, 93d Cong., 2d Sess., reprinted in 1974 *U.S. Code Cong. & Admin. News* 4890, 4892 ("Senate Report No. 383").

ERISA's purpose was to establish standards of conduct, to set forth the obligations of employee benefit plan fiduciaries and to provide "appropriate remedies, sanctions, and ready access to the federal courts" for the failure of a plan fiduciary to live up to its responsibilities under ERISA. Public Law 93-406, as codified at 29 U.S.C. §§1001-1461 (1982) §2(b). Congress intended "to remove jurisdictional and procedural obstacles which in the past appear to have hampered effective enforcement of *fiduciary responsibilities* under state law or recovery of benefits due to participants." S.Rep. 383, 93d Cong., 2d. Sess. reprinted in 1974 *U.S. Code Cong. & Admin. News 4871.* As this Honorable Court recognized in *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987), the civil enforcement provisions of ERISA §502(a) "are one of the essential tools for accomplishing the stated purposes of ERISA."

The ERISA civil enforcement scheme as set out in Section 502(a)(1)(B) was established to avoid conflicting and inconsistent state and local regulation of employee benefit plans. ERISA includes a broad preemption provision placing regulation of employee benefit plans with the federal government and in the federal courts. Senator Harrison Williams introduced the ERISA conference report stating "It should be stressed, that with the narrow exceptions specified in the bill, the substantive and enforcement provisions are intended to preempt the field for Federal regulations." Statement of Senator Harrison A. Williams, Jr. reprinted in 1974 *U.S. Code Cong. & Admin. News* 5177. Thus, federal law regulates *plans*, in furtherance of Congress' goals to make plans available, to protect plan participants by securing benefits and to avoid the possibility of conflicting state laws affecting plans. Federal law does not regulate those narrow exceptions specified in the bill. *One of those exceptions is insurance.*

Traditionally, states have had the right to regulate the insurance industry. Consistent with the McCarran-Ferguson Act and with ERISA's savings clause,[3] Congress has specifically left regulation of insurance to the states. As part of the states' responsibility to regulate insurance, many states have enacted Unfair Claims Practices statutes. California Insurance Code §790.03 is just such a statute but the California Supreme Court has determined that ERISA preemption prevents California Courts and the California Legislature from enforcing that statute.

B. JULIANO's Cause Of Action Against COMMERCIAL LIFE

For the purpose of a judgment on the pleadings, the allegations in the Complaint are deemed true. Therefore, COMMERCIAL LIFE violated the California Insurance Code and committed unfair insurance practices when it denied JULIANO's claim. Under California law, an insurance company's obligations to obey the Insurance Code are different, and beyond, the terms of the insurance policy. Damages for violation of the Code are not

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[3] Pertinent portions of the McCarran-Ferguson Act are set forth on pp. B-14, B-15, *infra*.

ERISA twice saves state law regulating insurance from preemption. First, ERISA provides that "nothing in this subchapter shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States . . . ." (29 U.S.C. §1144 subd. (d).) This portion of ERISA mandates that the McCarran Act, passed by Congress to reaffirm state power to regulate insurance, not be affected by ERISA.

Second, the "savings" clause of ERISA commands that ". . . nothing in this subchapter [ERISA's preemption provisions] shall be construed to exempt or relieve any person from any law of any state which regulates insurance . . . ." (29 U.S.C. §1144 subd. (b)(2)(A).)

the same as a claim for benefits under the plan. *Moore v. American United Life Insurance Company*, 150 Cal. App.3d 610 (1984). A cause of action for violation of the Insurance Code does not lie against anyone who is not in the business of insurance, and does not apply outside the insurance industry.[4]

California court decisions creating the cause of action for violation of the Code specifically stated that the purpose of Insurance Code §790.03, *et seq.* is to regulate trade practices in the business of insurance.[5] California Insurance Code §790.03 regulates only the insurer, it

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[4] *See, e.g., Dill v. Claims Administration Services, Inc.*, 178 Cal.App.3d 1184, 24 Cal.Rptr. 273 (1986) (self-insured employers' independently retained claims administrator is not in the business of insurance and not subject to section 790.03); *Richardson v. GAB Business Services, Inc.*, 161 Cal.App.3d 519, 207 Cal.Rptr. 519 (1984) (Section 790.03 is not applicable to self-insured corporations or independent adjusting firms); *Wolfrich Corporation v. United Services Auto Association*, 149 Cal.App.3d 1026, 1207-1210, 97 Cal.Rptr. 446, 448 (1983) (attorneys engaged by an insurance company are not engaged in the business of insurance and not liable under section 790.03); *Federal Trade Commission v. National Cas. Co.*, 357 U.S. 560, 78 S.Ct. 1260 (1958) (state laws proscribing unfair insurance advertising constitute state regulation of the business of insurance as that phrase is used in the McCarran-Ferguson Act); *Addrisi v. Equitable Life Assur. Society of the U.S.*, 503 F.2d 725, 728 (9th Cir. 1974), 420 U.S. 929, 95 S.Ct. 1129, *cert. den.* (1975), 421 U.S. 922, 95 S.Ct. 1590, *rehearing den.* (1975), *disapproved on other grounds, St. Paul Fire & Marine Ins. Co. v. Barry*, 438 U.S. 531, 98 S.Ct. 2923 (1978) (holding that Article 6.5 of the Insurance Code is a state law regulating the business of insurance). California Insurance Code §§790.01 and 790.02 recite that Article 6.5 applies to persons and practices "in the business of insurance."

[5] *See, Royal Globe Insurance Company v. Superior Court*, 23 Cal.3d 880, 884-885 (1979); *Shernoff v. Superior Court*, 44 Cal. App.3d 406 (1975); *Greenberg v. The Equitable Life Assurance Society of the U.S.*, 34 Cal.App.3d 994 (1973).

therefore does not come under the preemption clause at all. In *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 744 (1985), this Honorable Court held that a Massachusetts' statute requiring certain provisions in a health policy was not preempted by ERISA: "Laws that regulate only the insurer, or the way in which it may sell insurance, do not 'relate to' benefit plans in the first instance." California Insurance Code §790.03 is a direct regulation only of the insurer, it does not relate to a benefit plan.

Whether California Insurance Code §790.03 is a law regulating insurance is not seriously disputed. The California Supreme Court in this case *assumed* the Unfair Claims Practices Act was a law regulating insurance.[6]

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[6] *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 732 (1985), applied three criteria adopted by case law to define the "business of insurance" under the McCarran-Ferguson Act: " 'first, whether the practice has the effect of transferring or spreading a policyholder's risk; second, whether the practice is an integral part of the policy relationship between the insurer and the insured; and third, whether the practice is limited to entities within the insurance industry.' " Of the three judicially-created criteria concerning the "business of insurance" as established under the McCarran-Ferguson Act, the only factor which is not obviously apparent in California Insurance Code §790.03 is whether the section has the effect of transferring or spreading a policyholder's risk. Yet, even under that factor, §790.03 succumbs. For example, the statute requires a prompt, reasonable explanation of the basis relied upon in the insurance policy in relation to the facts or applicable law to justify denial of a claim. Under California law, an ambiguity in an insurance policy is to be resolved against the insurance policy. In assessing a risk actuarially, the likelihood of payment on the claim is affected by whether the resolution of an ambiguous term in the policy can be relied on to exclude coverage. Resolution in favor of payment for an ambiguous clause in the policy has the effect of transferring or spreading a policyholder's risk which, in another state, may not present a risk at all.

The Ninth Circuit in *Kanne v. Connecticut Gen. Life Ins. Co.*, 859 F.2d 96 (9th Cir. 1988), has also assumed, for the purpose of ERISA preemption, that California Insurance Code §790.03 regulates insurance. Thus, JULIANO's claim for damages for COMMERCIAL LIFE's violation of California's Insurance Code did not rise out of obligations in the policy and did not relate to his claim for benefits under the plan.

C. Effect Of Preemption On Jurisdiction And Remedies In States Which Have Regulated Insurance Through The Promulgation Of Unfair Claims Practices Acts

Referring to the Ninth Circuit decision in *Kanne*, *supra*, 859 F.2d 96, holding that a claim based on California Insurance Code §790.03 was preempted by ERISA, counsel for Connecticut General stated: "It would be difficult to overstate the importance of this decision, . . . over the next few years it could mean hundreds of millions of dollars." *Ripple-effect Ruling*, A.B.A. Journal, December 1, 1988, p. CE2. These hundreds of millions of dollars are going into the pockets of the insurance companies, not pension plans. As will be shown in section II, page 17 below, the critical difference between an underwritten insurance policy which an employee benefit plan purchases and a self-funded employee benefit plan illustrates that the effect of preemption on the public policy encouraging provision of plans is nil as it pertains to a private remedy for violation of a state Insurance Code.

As noted in the *Pilot Life* decision, one of ERISA's principal purposes was to provide speedy, equitable relief for participants in employee benefit plans who are unable to obtain their benefits. The practical effect of

ERISA, as the exclusive remedy in those states giving a private cause of action for violation of the state's Insurance Code, is to actually cut back on the ability of plan participants to get to court. Lawyers are unwilling or unable to protect workers in federal court for small medical claims against insurance companies who are capable of spending large amounts of money to hire lawyers to appear for them. *See generally*, Egelko, *Losing Faith in Bad Faith*, California Lawyer, October 1987, p. 27.

Since this court's opinion in *Pilot Life*, preemption has run amok. One frustrated district court recently said:

> The ERISA quicksand is fast swallowing up everything that steps in it or near it. This morass serves as the state for a theater of the absurd . . .
>
> If the congressional intention were to immunize insurance companies from liability whenever they can show some arguable reason for their refusal to pay a claim, Federal District Courts should have already ordered the appropriate rubber stamps. If this court is looking in the mouth of the gift horse that would allow the court to abdicate its routine responsibility, it is because there are countervailing forces called 'justice' and the seventh amendment's guarantee of a jury trial, both of which here give this court pause. . . .
>
> There is a growing phalanx of courts expressing the fear that ERISA will continue to expand and to preempt everything in its meandering path. Only Congress or the Supreme Court can rescue us from the quicksand. Meanwhile, this Court has paused, reflected, and concluded that Mrs. Jordan's case is not one in which she can be required to forego her traditional trial by

> jury.
> *Jordan v. Reliable Life Insurance Company*, 694 F.Supp. 822 (1988).

Justice Mosk dissenting in *Juliano* declared:

> There is a growing and ominous trend toward federal preemption of issues that belong within the sphere of control of the individual states. And these inroads into traditional federalism are taking place despite their inconsistency with pious rhetoric emanating from Washington about returning government to the people at state and local levels. Appendix "B" p. B-24.

Courts are reading *Pilot Life* so broadly that if an insurance company even asserts ERISA preemption, the door to court slams shut. Recently, the husband and children of a woman who died as a result of an insurance company's negligent verification of coverage brought a wrongful death negligence action in state court. After removal to federal court, the insurance company brought a Motion for Summary Judgment based on the fact that the wife and mother was insured under an employee benefit plan. The district court found preemption, granted summary judgment and cavalierly concluded:

> the only remaining question — whether ERISA itself might provide a remedy to plaintiffs — seems settled in favor of defendants by the holding in *Russell* [Citation]. To allow such claims or claims like the one at issue here, to go forward under ERISA would defeat the very purpose for which preemption is provided.

The action was not brought by a plan beneficiary for benefits under the plan. No plan benefits were sought, no breach of fiduciary duty was alleged. No negligent administration of a fiduciary's responsibility to an

employee welfare benefit plan was claimed. There was no involvement whatsoever by the employee, or the employer, as the plan.[7]

Courts have taken this court's opinion in *Pilot Life* far beyond the congressional intent in ERISA and even this court's opinion. The broad brush picture painted by Justice O'Connor's sweeping language in the second half of the *Pilot Life* opinion does not mention the effect of the opinion on those states which have regulated insurance by way of Unfair Claims Practices statutes. This silence portends ominous results for hundreds of thousands of state residents, like JULIANO, who have claims pending against insurance companies to enforce their rights under state laws regulating insurance. Petitioner respectfully requests this court give some guidance on this question and give more than lip service to the savings clause.

REASONS FOR GRANTING THE WRIT

I.

THE CALIFORNIA SUPREME COURT FINDING OF PREEMPTION IS NOT COMPELLED BY THE *PILOT LIFE* DECISION AND IS DIRECTLY CONTRARY TO THE RIGHTS OF STATES TO REGULATE INSURANCE.

In *Metropolitan Life Ins. Co. v. Massachusetts*, this Honorable Supreme Court said:

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[7] *Holmes v. Pacific Mutual Life Ins. Co.*, filed January 18, 1989, United States District Court, Central District of California, No. CV-FA-88-388-JSL, published at 89 Daily Journal D.A.R. 2984.

> We . . . must presume that Congress did not intend to pre-empt areas of traditional state regulation. 105 S.Ct. at p. 2389, 471 U.S. at p. 740
>
> The presumption is against pre-emption, . . . 105 S.Ct. at p. 2390, 471 U.S. at p. 741

It is clear that ERISA was established for the primary purpose of safeguarding employee pensions plans, and was addressed to the problem that many pension plans relied on by employees for retirement income were rendered insecure and illusory by various questionable practices by the people administering the plans. Indeed, ERISA's title itself refers only to "retirement income security." The type of health care benefits involved at bar were and are incidental and secondary to the plan. Thousands of employers who have not set up plans simply provide medical insurance as part of employee compensation. Nevertheless, California state courts find ERISA preemption even where there is no actual employee benefit plan.[8]

Congress' findings and declaration of policy are found in 29 U.S.C. §1001, subdivision (a):

> 1. "that despite the enormous growth in [employee benefit] plans many employees with long years of employment *are losing anticipated retirement benefits owing to the lack of vesting provisions in such plans*";
>
> 2. "that owing to the inadequacy of current minimum standards, the soundness and stability of plans with respect to adequate funds to pay promised benefits may be endangered";
>
> 3. "that owing to the termination of plans before requisite funds have been accumulated,

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[8] *See, e.g., Rizzi v. Blue Cross*, 206 Cal.App.3d 380 (1988).

employees and their beneficiaries have been deprived of anticipated benefits"; and

4. "it is therefore desirable in the interests of employees and their beneficiaries, for the protection of the revenues of the United States, and to provide for the free flow of commerce, that minimum standards be provided assuring the equitable character of such [employee benefit] plans and their financial soundness." (Emphasis added.)

Subdivision (b) of 29 U.S.C. §1001 refers exclusively to reporting and disclosure requirements, which are obviously aimed at insuring the objective of adequate funding of ERISA employee benefit plans, and are peculiarly applicable to funding of retirement benefits. Their applicability to medical and hospitalization plans is marginal. They have no affect on insurance.

Subdivision (c) of 29 U.S.C. §1001 refers only to private pension plans.

Thus, nothing in the Congressional findings and declarations of policy even remotely reflect a Congressional intention to preempt state laws aimed at protecting beneficiaries of medical, hospital or disability insurance contracts. To the contrary, these sections plainly and explicitly state that the "well-being and security of millions of employees and their dependents" is the primary purpose of ERISA. 29 U.S.C. §1001, subdivision (a).

Long before the potential problems affecting employee retirement plans came to the attention of Congress, Congress established the national policy of state primacy in the regulation of insurance by enacting the McCarran-Ferguson Act, 15 U.S.C. §§1012, *et seq*. The McCarran-Ferguson Act provides, in pertinent part:

> Regulation by State law: Federal law relating specifically to insurance; applicability of certain Federal laws after June 30, 1948. (a) The business of insurance, and every person engaged herein, shall be subject to the laws of the several States which relate to the regulation of taxation of such business.
>
> (b) No act of Congress shall be construed to invalidate, impair, or supersede any law enacted by the State for the purpose of regulating the business of insurance . . .

15 U.S.C. §1012 (1976).

In *SEC v. National Securities, Inc.*, 393 U.S. 453 (1969), this Court observed:

> The McCarran-Ferguson Act was an attempt to turn back the clock, to assure that the activities of insurance companies in dealing with their policyholders would remain subject to state regulation.
>
> . . . Insurance companies may do many things which are subject to paramount federal regulation; only when they are engaged in the 'business of insurance' does the statute apply . . . Congress was concerned with the type of state regulation that centers around the contract of insurance, the transaction which *Paul v. Virginia* [8 Wall. 168, 19 L.Ed. 357] held was not 'commerce.' The relationship between insurer and insured, the type of policy which could be issued, its reliability, interpretation, and enforcement — these were the core of the 'business of insurance.' Undoubtedly, other activities of insurance companies relate so closely to their status as reliable insurers that they too must be placed in the same class. But whatever the exact scope of the statutory term,

> it is clear where the focus was — it was on the relationship between the insurance company and the policyholder. Statutes aimed at protecting or regulating this relationship, directly or indirectly, are laws regulating the 'business of insurance.'

When Congress drafted ERISA they were "primarily concerned with the possible misuse of plan assets, and with remedies that would protect the entire plan, rather than with the rights of an individual beneficiary." *Massachusetts Mutual Life Ins. Co. v. Russell*, 473 U.S. 134 (1985).

No one, not Congress, not insurance companies, not employers, no one, ever dreamed that ERISA would preempt a state's ability to regulate insurance by creating a private right of action for violation of that state's Insurance Code. As a matter of fact, at the time ERISA was drafted, insurance companies had long complied with different and inconsistent state regulation of insurance. The insurer is not the plan. ERISA regulates employer benefit plans. States regulate insurance. An employer may purchase insurance as one of several services or benefits provided by the plan. However, the insurance policy purchased is no more than any other service or product necessary for the plan's operation. For example, if the plan fiduciary required office space in a building, that building would have to comply with local building codes. If a plan participant was injured as a result of faulty construction in violation of the building code, his cause of action against the builder would not be preempted by ERISA. This analysis holds true regardless of whether he entered the building in order to obtain benefits under the plan.

This court's decision in *Pilot Life* did not address a claim based on a state statute regulating insurance. In fact, when faced with a state statute which obviously did

regulate insurance, this court held there was no preemption. *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985). Petitioner respectfully requests this court grant this Petition for Writ of Certiorari and secure the right of state legislatures to regulate insurance by enforcement of Unfair Claims Practices Acts.

II.

CRITICAL DIFFERENCES BETWEEN A SELF-FUNDED PLAN AND A PLAN'S PURCHASE OF AN INSURANCE POLICY WERE NOT BRIEFED NOR CONSIDERED WHEN THIS COURT DECIDED *PILOT LIFE*.

This Honorable Court did not have the benefit of briefing on the critical distinction between self-funded employee benefit plans which provide medical benefits and a plan's purchase of an insurance policy to provide medical benefits. It is this distinction that points out the important questions and, the error, presented in the California Supreme Court's decision in *Juliano*.

Permitting a plan participant to obtain additional relief for oppressive and fraudulent conduct by an insurance company is consistent with ERISA and "would best effectuate the underlying purpose of ERISA — enforcement of strict fiduciary standards of care in the administration of all aspects of pension plans and the promotion of the best interests of participants and beneficiaries." See Justice Brennan's concurring opinion in *Massachusetts Mutual Life Ins. Co. v. Russell*, 473 U.S. 134 (1985) at p. 158. Justice Brennan was referring to trust law principals, which are not expressly exempted in the ERISA savings clause as are banking, securities and insurance laws. These express exemptions present all

the more reason to permit states to regulate insurance by regulating claims practices.

Whether or not extracontractual damages are available against a plan fiduciary for failure to provide benefits under the plan, the obligations of an insurance company as set forth by state insurance law remain unchanged and state law providing damages for violation of the insurance regulation has no effect on the plan or on the relationship between the plan fiduciary and the plan beneficiary. The greatest area of sensitivity concerning a state's creation of remedies, in addition to those provided by ERISA has been the issue of punitive damages. *See Russell, supra.* Yet, California does not permit an insurance company to pass on costs for punitive damage awards to policyholders by increased premiums and, therefore, the plan is unaffected by extracontractual remedy against the insurer.[9]

Insurance companies are obligated to obey the state's Insurance Code whether or not the policy has been purchased incident to an employee benefit plan or by an individual. The only effective difference of ERISA preemption in states with separate remedies for violation of the Insurance Code is that the employee is entitled to *less* protection than the individual. This holds true although there is no appreciable benefit to the plan by way of reduced premium for reduced risk. If preemption is necessary to secure low cost medical benefits for participants in employee benefit plans, costs for exempt groups would be higher than for employee benefit plans covered by ERISA. The fact is, since this court's decision in *Pilot Life*, not one insurance company in

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[9] "Financial Statement Accounting for Punitive or Monetary Damages and Claim and Award Contingencies, and Reports to the Insurance Commissioner of Material Awards, Settlements, Fines, and Penalties," State of California, Department of Insurance Accounting Statement 84-1 issued November 26, 1984.

California has lowered group rates as a result of the decrease in potential risk for group insurance claims in California.

Two of this court's recent decisions have, by inference, recognized a difference between rules which should apply to self-funded plans and those which should apply to underwritten insurance policies. *Fort Halifax Packing Co., Inc. v. Coyne*, 107 S.Ct. 2211 (1987) concludes that a statute providing a one-time severance payment to employees in the event of plant closing was not preempted by ERISA. *Fort Halifax* declared ERISA was not implicated because ERISA was enacted to require disclosure and provide safeguards in the establishment, operation and administration of employee benefit plans and to prevent particular abuses of the fiduciaries managing the plan, such as self-dealing, imprudent investing, and misappropriation of plan funds. *Id.* at pp. 2219-2220. Analyzing *Fort Halifax* in determining whether a group insurance plan was preempted by ERISA, a California Court of Appeal has reasoned:

> Applying by analogy the Fort Halifax analysis here, the line of demarcation between ERISA plans and non-ERISA plans depends on the level of involvement by the employer in the program so as to warrant federal regulation of the administrative integrity of the program. That is, when employers provide benefits to employees in a manner which involves the employer's administration of funds to be used for the employees, ERISA's concern with regulating the administrative integrity of the program arises.
>
> *Rizzi v. Blue Cross*, 206 Cal.App.3d 380 (1988)

This court's February 21, 1989 decision in *Firestone Tire and Rubber Co. v. Bruch*, No. 87-1054, sets forth

reasons for removing the arbitrary and capricious standard for denial of ERISA claims when the denial is by a nonfiduciary. Following *Firestone*, claims for benefits must be reviewed under a de novo standard unless the plan administrator or fiduciary has been given *express* discretionary authority to determine benefits. Yet the mere fact that an administrator has been given discretionary authority to deny claims for benefits cannot be interpreted, under *Firestone*, to give complete discretion to the administrator.

Applying the *Firestone* analysis in the insurance context points out the critical difference between self-funded and underwritten medical coverage. Under *Firestone*, a self-funded plan where the fiduciary has been given complete express authority to determine eligibility and benefits the employer is entitled to preemption and the employee is limited to ERISA remedies. This furthers Congressional goals protecting the integrity of the plan and securing benefits for the employee. However, with the underwritten policy, an insurance company would be required to obey state law in its conduct concerning claim review and payment, subject to the court's de novo review of its decision. This poses no greater burden on the insurance company than is already required by state law and has no effect on the employee benefit plan.

This court should grant this Petition for Writ of Certiorari in order to consider briefing on the critical differences between ERISA preemption as it affects self-funded plans and as it affects employee benefit plans which contract with insurance companies by purchasing insurance.

III.

CONGRESSIONAL INTENT CREATING ERISA PREEMPTION IS CONSISTENT WITH SAVING FROM PREEMPTION A STATE REMEDY DESIGNED TO REGULATE AND ENFORCE INSURANCE LAWS.

In his dissenting opinion in this case, Justice Mosk argues that the state's creation of a remedy in addition to those provided by ERISA, does not affect the enforcement scheme of the federal statute.

> [T]he majority hold that §790.03(h) is not saved from preemption and hence that Juliano's claim under the statutory provision is barred. In support they assert that ERISA has established a civil enforcement scheme that provides exclusive remedies. That may be true. But ERISA's scheme defines remedies *for the violation of rights granted employees under the terms of plans within the coverage of the act and under the act itself.* (See ERISA §502(a), 29 U.S.C. §1132(a).) [Footnote omitted.] By contrast, the Unfair Trade Practices Act, of which §790.03(h) is a part, has established a civil enforcement scheme that provides remedies *for the breach of duties imposed on insurers under the laws of the State of California.* In a word, the remedy of ERISA may be exclusive in their own sphere, but they do not extend into the sphere occupied by §790.03(h). [Citation]
>
> Thus, ERISA does not preempt §790.03(h), but expressly saves the provision as a law "regulating insurance." Further, the civil enforcement scheme of the federal statute does not

> displace the civil enforcement scheme of the state act: the former concerns the rights of employees under covered plans, the latter the duties of insurers under state law. See Appendix "B" pp. B-23, B-24.

Even though no United States Supreme Court decision has set forth an interpretation of ERISA preemption that would require wholesale nullification of a state law regulating insurance, state and federal courts across the country have read such a result between the lines in *Pilot Life*. The California Supreme Court, in this case, stated:

> Our reading of *Pilot Life* accords with that of the Ninth Circuit in *Kanne*. [*Kanne v. Connecticut General Life Ins. Co.* 859 F.2d 96] We are persuaded that §790.03, subdivision (h) would still be preempted by ERISA even if it were found to be within the scope of the savings clause as a law regulating insurance. This conclusion is compelled by the Supreme Court's discussion of Congressional intent, which the court cited as the most significant factor in its determination. See Appendix "B" p. B-14.

As discussed above, the decision of this Honorable Court in *Metropolitan Life Ins. Co. v. Massachusetts*, *supra*, clearly shows that ERISA preemption does not apply to state laws enacted to protect beneficiaries of health care insurance. That case states the presumption against preemption of areas of "traditional state regulation" (471 U.S. at p. 740). The opinion further states that "we are not inclined to read limitations into federal statutes in order to enlarge their preemptive scope" (471 U.S. at p. 741) and this Honorable Court rejected the contention that "Congress intended [a] narrow reading of the savings clause," 29 U.S.C. §1144(b)(2)(A). 471 U.S. at pp. 745-746.

Thus, the logical extension of *Metropolitan Life Insurance Co.* would find no preemption of a specific state statute which, on its face, states that its purpose is to regulate insurance and, under either the common sense test or the three factors announced by courts interpreting the McCarran-Ferguson Act, regulates insurance.

Pilot Life does not require and this court should not permit preemption of state laws regulating insurance. The second half of the *Pilot Life* decision 107 S.Ct. at pp. 1555-1558 discussing exclusivity of ERISA remedies, should only apply to actions in which the savings clause does not apply. Otherwise, nothing is saved by the savings clause and this Honorable Court's detailed discussion and analysis of whether the Mississippi common law is a state law regulating insurance is superfluous. The California Supreme Court in this case stated: "We conclude that *Pilot Life's* express holding controls the resolution of this case. [Footnote omitted.] *Pilot Life* is directly on point regarding the exclusivity issue and its conclusion is inescapable." Appendix "B," p. B-15. The JULIANO court placed great emphasis on the important policy of promoting uniformity in employee benefit plan remedy by eliminating the potential for conflicting standards of recovery. This reliance is misplaced. As discussed above, the remedies for violation of the Insurance Code do not affect uniformity of remedies available under employee benefit plans and do not create the potential for conflicts amongst the various states of laws affecting the plans.

Concern for the aftereffects of *Pilot Life* foreclosing remedies other than those provided in ERISA for the denial of insurance claim benefits reached Congress late last year. In conjunction with H.R. 4845, the "Miscellaneous ERISA Amendments Act of 1988," the committee report rejected some courts' narrow view that ERISA contains exclusive remedies and makes the following statement:

> The Committee believes that the legislative history of ERISA and subsequent expansions of ERISA support the view that Congress intended for the courts to develop a federal common law with respect to employee benefit plans, including the development of appropriate remedies, even if they are not specifically enumerated in §502 of ERISA. Since the issue of preemption and civil remedies under ERISA is within the exclusive purview of the labor committees of Congress, the Committee has, over the years, considered the option of amending the statute to encompass specifically several additional remedies. In light of the legislative history on this issue, however, the Committee believes such action is unnecessary. The Committee reaffirms the authority of the federal court to shape legal and equitable remedies to fit the facts and circumstances of the cases before them, even though those remedies may not be specifically mentioned in ERISA itself. In cases in which, for instance, facts and circumstances show that the processing of legitimate benefit claims has been unreasonably delayed or totally disregarding by an insurer, an employer, a plan administrator, or a plan, the Committee intends the federal courts to develop federal common law of remedies, including (but certainly not limited to) the imposition of punitive damages on the person responsible for the failure to pay claims in a timely manner.

The committee report emphasizes the need for effective remedies against the insurer, the employer, and the plan. Consistent with the legislative intent underlying creation of ERISA and this most recent pronouncement of legislative intent, this court should settle the question

of whether the states remain free to regulate insurance and clarify that this court's decision in *Pilot Life* does not preclude the State of California from enacting or enforcing laws regulating insurance even if those laws contain civil enforcement provisions against insurance companies which are not provided in ERISA.

CONCLUSION

Congress could never have intended the results which have flowed from this court's decision in *Pilot Life* as the various state and federal courts are faced with the question of insurance regulation under Unfair Claims Practices Acts. ERISA was designed to secure workers' ability to collect pensions. At the time ERISA was written, correction of unfair insurance claims practices was not even a problem considered or addressed by Congress. Many states had statutes and case law regulating insurance claims practices. McCarran-Ferguson was well in place. Courts and industry alike assumed ERISA had no effect on these laws. Not one of the insurance industry briefs filed in any court seriously denies the catastrophic effect of ERISA preemption of claims for medical benefits in those states with carefully reasoned and specific unfair claims practice legislation. This Petition for Certiorari should be granted. The wholesale emasculation of the states' rights to regulate insurance should be corrected by this Honorable Court.

Dated: March 15, 1989

Respectfully submitted,

SHERNOFF, SCOTT & BIDART

By: MARIAN HAYCOCK TULLY

Attorneys for Petitioner

APPENDIX A

Supreme Court No.: S003129
Fourth District, Division One, No. D006995
Superior Court No.: 542103
Trial Judge: Honorable Vincent P. DiFiglia

IN THE SUPREME COURT
OF THE STATE OF CALIFORNIA

SUPREME COURT
FILED
JAN 4 1988
Laurence P. Gill, Clerk

COMMERCIAL LIFE INSURANCE COMPANY
and AUTOMATIC DATA PROCESSING, INC.
Petitioners,

vs.

SUPERIOR COURT OF THE STATE
OF CALIFORNIA FOR THE COUNTY
OF SAN DIEGO,
Respondent.

JOSEPH V. JULIANO,
Real Party-in-Interest.

ALTERNATIVE WRIT OF MANDATE

TO RESPONDENT, SUPERIOR COURT OF THE STATE OF CALIFORNIA FOR THE COUNTY OF SAN DIEGO:

A petition for review of a decision of the Court of Appeal for the Fourth Appellate District, Division 1, denying a petition for writ of mandate arising out of an

order entered by you in the above cause on September 21, 1987, has been filed in this Court. After reviewing that petition, this Court finds good cause to order that an alternative writ of mandate issue, and to require you to:

(a) Either vacate the September 21, 1987, order in San Diego Superior Court action number 542103 entitled *Joseph V. Juliano v. Automatic Data Processing, Inc., et al.*, denying petitioner's motion for judgment on the pleadings with respect to the fifth count in real party in-interest's complaint, and to enter a new and different order granting said motion,

(b) Or, in the alternative, show cause before this Court in its courtroom, when the proceeding is ordered on calendar, why a peremptory writ of mandate ordering you to do so should not issue.

The written return to the writ is to be served and filed on or before January 19, 1988.

WITNESS the Honorable Malcom M. Lucas, Chief Justice of the Supreme Court of the State of California, attested by my hand and the Seal of this Court this 4th day of January 1988.

LAWRENCE P. GILL
Clerk of the Supreme Court

(Seal)

By: /s/ R. Barrow
Deputy Clerk

APPENDIX B

COPY

IN THE SUPREME COURT
OF THE STATE OF CALIFORNIA

SUPREME COURT
FILED
DEC 15 1988
Clerk
Deputy

COMMERCIAL LIFE INSURANCE COMPANY, et al.,
Petitioners,
v.
THE SUPERIOR COURT OF SAN DIEGO COUNTY,
Respondent;

JOSEPH V. JULIANO,
Real Party in Interest.

S003129
(Ct. of Appeal No. D006995)
(Super. Ct. No. 542103)

SEE DISSENTING OPINION

We are asked to decide whether the Employee Retirement Income Security Act of 1974 (ERISA) (29 U.S.C. § 1001 *et seq.*) preempts a private cause of action brought under California Insurance Code section 790.03, subdivision (h),[1] where the action asserts a claim arising from an employee benefit plan. We conclude that ERISA does preempt such an action.

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[1] Unless otherwise provided, all statutory references are to the Insurance Code.

Joseph V. Juliano's employer sponsored an employee benefit plan insured by Commercial Life Insurance Company and Automatic Data Processing, Inc. (collectively referred to as Commercial). It is undisputed that the plan was the type regulated by ERISA. The benefits under the plan included group term life insurance, accidental death and dismemberment insurance, major medical expense benefits, prescription drug and medicine benefits, and dental care benefits.

Juliano suffered from diabetes, which adversely affected his eyesight. Doctors recommended surgery. Following the surgery, Juliano forwarded his medical bills to Commercial. Commercial refused payment, claiming that the treatment was not covered by the plan because it arose from a preexisting condition.

Juliano brought suit against Commercial. The complaint alleged eight common law causes of action for bad faith, waiver, and estoppel. The complaint also alleged a single statutory cause of action for bad faith under section 790.03, subdivision (h).[2] Commercial

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[2] Section 790.03 provides in pertinent part:

"The following are hereby defined as unfair methods of competition and unfair and deceptive acts or practices in the business of insurance. [¶] . . . (h) Knowingly committing or performing with such frequency as to indicate a general business practice any of the following unfair claims settlement practices: [¶] (1) Misrepresenting to claimants pertinent facts or insurance policy provisions relating to any coverages at issue. [¶] (2) Failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies. [¶] (3) Failing to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under insurance policies. [¶] (4) Failing to affirm or deny coverage of claims within a reasonable time after proof of loss requirements have been completed and submitted by the insured. [¶] (5) Not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims in which

(continued)

answered the complaint. Then, prior to trial, Commercial filed a motion for judgment on the pleadings,

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(ftn. continued)

liability has become reasonably clear. [¶] (6) Compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by such insureds, when such insureds have made claims for amounts reasonably similar to the amounts ultimately recovered. [¶] (7) Attempting to settle a claim by an insured for less than the amount to which a reasonable man would have believed he was entitled by reference to written or printed advertising material accompanying or made part of an application. [¶] (8) Attempting to settle claims on the basis of an application which was altered without notice to, or knowledge or consent of, the insured, his representative, agent, or broker. [¶] (9) Failing, after payment of a claim, to inform insureds or beneficiaries, upon request by them, of the coverage under which payment has been made. [¶] (10) Making known to insureds or claimants a practice of the insurer of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration. [¶] (11) Delaying the investigation or payment of claims by requiring an insured, claimant, or the physician of either, to submit a preliminary claim report, and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information. [¶] (12) Failing to settle claims promptly, where liability has become apparent, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage. [¶] (13) Failing to provide promptly a reasonable explanation of the basis relied on in the insurance policy, in relation to the facts or applicable law, for the denial of a claim or for the offer of a compromise settlement. [¶] (14) Directly advising a claimant not to obtain the services of an attorney. [¶] (15) Misleading a claimant as to the applicable statute of limitations."

(continued)

alleging that each cause of action set forth by Juliano was preempted by ERISA. In response, Juliano conceded that *Pilot Life Ins. Co. v. Dedeaux* (1987) __ U.S. __ [107 S.Ct. 1549] compelled the conclusion that his common law causes of action were preempted by ERISA. However, he argued that his statutory cause of action under section 790.03, subdivision (h), was not preempted. The trial court agreed with Juliano and denied Commercial's motion for judgment on the pleadings as to the statutory cause of action for violation of section 790.03, subdivision (h).

Commercial filed a petition for writ of mandate and/or prohibition in the Court of Appeal. The Court of Appeal summarily denied the petition. We granted review and issued an alternative writ.

In his return to the writ, Juliano argues that section 790.03, subdivision (h) is exempt from preemption because it "regulates insurance" within the meaning of ERISA's "saving clause."

I

ERISA comprehensively regulates employee pension and welfare plans. (*Metropolitan Life Ins. Co. v. Massachusetts* (1985) 471 U.S. 724, 732; 29 U.S.C. §§ 1003, 1002.) The act protects interstate commerce and the participants of employee benefit plans by requiring disclosure to participants, establishing standards of conduct and fiduciary duties, and providing for remedies, sanctions, and ready access to federal courts. (29 U.S.C. § 1001(b).) While ERISA imposes upon

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(ftn. continued)

In *Royal Globe Ins. Co. v. Superior Court* (1979) 23 Cal.3d 880, we held that private litigants could sue to enforce certain provisions of section 790.03, subdivision (h). However, *Royal Globe* was prospectively overruled in *Moradi-Shalal v. Fireman's Fund Insurance Cos.* (1988) __ Cal.3d __.

benefit plans a variety of substantive requirements relating to participation, funding, and vesting, it contains almost no federal regulation of the substantive terms of benefit plans. (*Metropolitan Life, supra*, 471 U.S. at p. 732.)

ERISA's civil remedies are comprehensive in their scope. A participant or beneficiary of an ERISA plan may bring a civil action for monetary relief from an administrator's failure to provide requested information, or to recover benefits or enforce present or future rights under the terms of the plan. (29 U.S.C. § 1132(a).) Moreover, a participant, beneficiary, or fiduciary may sue to enjoin any act which violates ERISA or the terms of the plan, and may also sue for other equitable relief, or for breach of fiduciary duty. (*Ibid.*) The Secretary of Labor may also bring an action for breach of fiduciary duty, for injunctive or equitable relief, for relief from failure of the administrator to provide information, or to collect any civil penalties under the act. (*Ibid.*)

In addition, ERISA contains detailed provisions for claims enforcement and procedure. (29 U.S.C. §§ 1132, 1133.) Moreover, regulations promulgated by the Department of Labor pursuant to 29 United States Code section 1133 provide specific claims-handling rules and procedures. (29 C.F.R. § 2560.502-1 *et seq.*)

ERISA also contains a broad preemption provision. The "preemption clause" provides: "Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975." (29 U.S.C. § 1144(a).) The breadth of the preemption clause is qualified, however, by the "saving clause," which provides in

pertinent part: "[N]othing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities." (29 U.S.C. § 1144(b)(2)(A).)

II

Our resolution of this case is aided by previous decisions of the United States Supreme Court. In *Metropolitan Life Ins. Co. v. Massachusetts, supra*, 471 U.S. 724, the Supreme Court addressed the question whether ERISA preempted a Massachusetts statute which required certain minimum mental-health-care benefits to be included in employee health-care plans. The Massachusetts statute regulated the substantive terms of insurance contracts by requiring health-insurance policies to provide, among other things, 60 days of coverage for confinement in a mental hospital and certain minimum outpatient benefits.

Noting that there is a presumption against preemption (*Metropolitan Life, supra*, 471 U.S. at p. 741), the court concluded that the Massachusetts statute was saved from preemption because it regulated insurance within the meaning of ERISA's saving clause.

The court applied the following analysis to determine whether the Massachusetts statute regulated insurance. Initially, the court took a "common sense" view of the matter, concluding that the Massachusetts statute regulated insurance because it controlled the substantive terms of insurance policies. (*Metropolitan Life, supra*, 471 U.S. at p. 740.)

Next, the court applied three criteria adopted by case law to define the "business of insurance" under the McCarran-Ferguson Act (15 U.S.C. § 1011 *et seq.*):[3]

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[3] The McCarran-Ferguson Act pertains to the regulation of insurance. Section 1011 provides: "Congress declares that the

(continued)

" '*first*, whether the practice has the effect of transferring or spreading a policyholder's risk; *second*, whether the practice is an integral part of the policy relationship between the insurer and the insured; and *third*, whether the practice is limited to entities within the insurance industry.' " (*Metropolitan Life, supra*, 471 U.S. at p. 743, quoting *Union Labor Life Ins. Co. v. Pireno* (1982) 458 U.S. 119, 129, original emphasis.)

The United States Supreme Court found that all three McCarran-Ferguson factors were satisfied. Addressing the first factor, the court held that the Massachusetts statute "obviously" effected the spreading of risk, because the statute "was intended to effectuate the legislative judgment that the risk of mental-health care should be shared." (*Metropolitan Life, supra*, 471 U.S. at p. 743.) Turning to the second factor, the court held that "mandated-benefit laws directly regulate an integral part of the relationship between the insurer and the policyholder by limiting the type of insurance that an insurer may sell to the policyholder." (*Ibid.*) The third factor was also met, because the Massachusetts statute imposed requirements only on insurers. (*Ibid.*)

The Supreme Court had a further opportunity to determine the scope of ERISA preemption in *Pilot Life Ins. Co. v. Dedeaux, supra*, 107 S.Ct. 1549. *Pilot Life* presented the issue whether ERISA preempted common law tort and contract actions arising from the improper processing of a claim for benefits under an insured employee benefit plan. Everate Dedeaux injured his back while working for Entex, Inc. Dedeaux sought disability benefits under an employee benefit plan insured by Pilot Life Insurance Company (Pilot Life).

(ftn. continued)
continued regulation and taxation by the several States of the business of insurance is in the public interest, and that silence on the part of the Congress shall not be construed to impose any barrier to the regulation or taxation of such business by the several States."

Pilot Life terminated Dedeaux's benefits after two years, and Dedeaux brought a diversity suit in federal district court. Dedeaux alleged Mississippi common law claims for fraud, breach of fiduciary duty, and breach of contract. However, he did not assert any of the causes of action available to him under ERISA. Pilot Life moved for summary judgment, arguing that ERISA preempted all of Dedeaux's claims. The district court granted summary judgment, but the circuit court of appeals reversed.

The Supreme Court reversed the court of appeals. Stating that "the express pre-emption provisions of ERISA are deliberately expansive, and designed to 'establish pension plan regulation as exclusively a federal concern' " (*Pilot Life, supra*, 107 S.Ct. at p. 1552), the Supreme Court concluded that Dedeaux's claims were preempted. Although the Supreme Court applied the *Metropolitan Life* analysis to support its conclusion, it relied primarily on the "clear expression of congressional intent that ERISA's civil enforcement scheme be exclusive" to find preemption. (*Id.* at p. 1558.)

Proceeding first with the *Metropolitan Life* analysis, the court applied the "common-sense view" to find that the Mississippi common law of bad faith could not be construed as a law that regulated insurance within the meaning of the saving clause. "A common-sense view of the word 'regulates' would lead to the conclusion that in order to regulate insurance, a law must not just have an impact on the insurance industry, but be specifically directed toward that industry." (*Pilot Life, supra*, 107 S.Ct. at p. 1554.)

The court next applied the McCarran-Ferguson factors. Regarding the first factor — whether the practice has the effect of spreading policyholder risk — the court determined, without explanation, that unlike the mandated-benefits law in *Metropolitan Life*, the

Mississippi common law did not effect a spreading of policyholder risk. (*Pilot Life, supra*, 107 S.Ct. at p. 1554.) Addressing the second factor — whether the practice is an integral part of the policy relationship between the insurer and the insured — the court stated that the Mississippi common law could perhaps be considered a part of the insurer-insured relationship, but that the connection was attenuated at best. "In contrast to the mandated-benefits law in *Metropolitan Life*, the common law of bad faith does not define the terms of the relationship between the insurer and the insured; it declares only that, whatever terms have been agreed upon in the insurance contract, a breach of that contract may in certain circumstances allow the policyholder to obtain punitive damages." (*Pilot Life, supra*, 107 S.Ct. at p. 1555.) Thus, although the common law could be considered a "part" of the insurer-insured relationship, it could not be considered an "integral" part. (*Ibid.*) Finally, applying the third factor — whether the practice is limited to entities within the insurance industry — the court noted that the common law had general application to all members of the community, and was not directed solely to the insurance industry. (*Ibid.*) The court concluded that the Mississippi common law failed the McCarran-Ferguson test. (*Id.* at pp. 1554-1555.)

The court easily distinguished its *Pilot Life* holding from the holding in *Metropolitan Life*. (*Pilot Life, supra*, 107 S.Ct. at p. 1558.) *Metropolitan Life* did not involve a state law that conflicted with a substantive provision of ERISA, because ERISA — unlike the Massachusetts law in *Metropolitan Life* — "does not regulate the substantive content of welfare-benefit plans." (*Metropolitan Life, supra*, 471 U.S. at p. 732.) However, in *Pilot Life* the common law remedies asserted by Dedeaux conflicted with ERISA's remedies. Therefore, the court in *Pilot Life* went on to determine

whether Congress intended the ERISA remedies to be exclusive.

The Supreme Court concluded that Congress clearly expressed an intent that the civil enforcement provisions of ERISA be the exclusive vehicle for actions by ERISA-plan participants and beneficiaries asserting improper processing of a claim for benefits. (*Pilot Life, supra*, 107 S.Ct. at p. 1555.) The court's determination of exclusivity is supported by the language and structure of ERISA's civil enforcement provisions and by the legislative history of the act.[4] (*Ibid.*) "In sum, the detailed provisions of § 502(a) [of ERISA (29 U.S.C. § 1132)] set forth a comprehensive civil enforcement scheme that represents a careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans. The policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA." The court added: "The deliberate care with which ERISA's civil enforcement remedies were drafted and the balancing of policies embodied in its choice of remedies argue strongly for the conclusion that ERISA's civil enforcement remedies were intended to be exclusive." (*Pilot Life, supra*, 107 S.Ct. at pp. 1556-1557.)

Metropolitan Life and *Pilot Life* provide helpful guidance in this case, but the Supreme Court has not

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[4] The legislative history indicates that Congress intended ERISA to have the same preemptive force as the exclusive remedy provisions of section 301 of the Labor-Management Relations Act (LMRA) (61 Stat. 156, 29 U.S.C. § 185). (*Pilot Life, supra*, 107 S.Ct. at pp. 1555, 1557-1558.) The Supreme Court stated that the powerful pre-emptive force of the LMRA displaced all state actions within its scope. (*Id.* at p. 1557.)

addressed the precise issue posed here. A number of other courts, however, have faced this issue.

Roberson v. Equitable Life Assur. Soc. of U.S. (C.D.Cal. 1987) 661 F.Supp. 416 involved facts almost identical to those at bar. Plaintiff Donald Roberson brought an action in state court against The Equitable Life Assurance Society of the United States (Equitable), alleging that Equitable failed to pay all benefits due under an ERISA-regulated employee benefit plan. Roberson's complaint stated seven common law causes of action. The complaint also stated a single statutory cause of action under section 790.03, subdivision (h), and a single cause of action against his employer, Alpha Microsystems, for ERISA remedies. The defendants removed the case to federal court and moved for summary judgment in light of *Pilot Life*. Roberson conceded that all of his common law claims were preempted by ERISA, but argued that his statutory claim under section 790.03, subdivision (h) was not preempted because section 790.03, subdivision (h) regulates insurance within the meaning of ERISA's saving clause.

The district court applied the analysis set forth in *Metropolitan Life* and *Pilot Life*. The court initially concluded that "common sense" suggested that section 790.03, subdivision (h) regulates insurance. "The most persuasive argument in support of saving the California statute is its obvious connection to regulating insurance. Thus, under the 'common sense' test, it would strain logic to argue that section 790.03(h) is not specifically directed toward the insurance industry." (*Roberson, supra*, 661 F.Supp. at p. 422.)

The court determined, however, that section 790.03, subdivision (h) did not satisfy two of the three McCarran-Ferguson criteria. "First, it would not appear that 790.03(h) has any effect of transferring or spreading policyholder risk. Unlike the Massachusetts

law in *Metropolitan Life*, section 790.03(h) does not purport to regulate the substantive terms or content of insurance policies by mandating benefits. Rather, subsection (h) of section 790.03 primarily is aimed at the procedural aspect of processing and settling claims." (*Roberson, supra*, 661 F.Supp. at p. 422.) Turning to the second McCarran-Ferguson factor, the court stated: "Despite its providing for more specific standards of conduct in processing claims for benefits, section 790.03(h) is not 'integral' to the insurer-insured relationship. Section 790.03(h) does not regulate the terms of the contract itself and hence does not regulate 'the business of insurance' as that term is defined under the McCarran-Ferguson Act." (*Ibid.*) The court determined that section 790.03, subdivision (h) is directed toward the insurance industry, and therefore the third McCarran-Ferguson factor was satisfied. But the court cited authority for the proposition that the satisfaction of only one factor is insufficient. (*Ibid.*, citing *United Food & Commercial Workers v. Pacyga* (9th Cir. 1986) 801 F.2d 1157, 1161.)

Finally, the court in *Roberson* followed *Pilot Life's* holding that ERISA's remedies are exclusive. In *Pilot Life*, "because the civil enforcement provisions of ERISA were intended to provide the exclusive remedies for mishandling of claims, the Mississippi law was in conflict with ERISA and was therefore pre-empted. [¶] The same potential for conflict with ERISA's civil enforcement provisions exists with respect to California Insurance Code Section 790.03(h). . . . Section 790.03(h) . . . provides that either an insured *or* third-party claimant may sue an insurer for engaging in unfair claims settlement practices . . . . Such provisions reach impermissibly beyond the scope of ERISA. *See, e.g. [Massachusetts Mut. Life Ins. Co. v. Russell* (1985) 473 U.S. 134, 145-148] (holding that ERISA does not grant a private right of action for delay in processing benefit claims)." (*Roberson, supra*, 661 F.Supp. at p.

423, original emphasis.) The court concluded: "Thus, even assuming that section 790.03(h) regulates insurance and is therefore within the scope of the saving clause, it must be pre-empted for infringing on the same exclusive civil remedy provisions that were dispositive in *Pilot Life*." (*Roberson, supra*, 661 F.Supp. at p. 424, fn. omitted.)

In *Kanne v. Connecticut General Life Ins. Co.* (9th Cir. 1988) __ F.2d __ (88 Daily Journal D.A.R. 12662), the Ninth Circuit Court of Appeals began where *Roberson* left off: It found the conclusion inescapable that section 790.03, subdivision (h) is preempted under *Pilot Life*. Although the Ninth Circuit stated its general agreement with the *Roberson* opinion (*id.* at p. 12665, fn. 6), it was willing to assume for purposes of its analysis that section "790.03(h) is a law regulating insurance under the savings clause." (*Id.* at p. 12664.)

The *Kanne* court rejected the plaintiffs' argument for limiting *Pilot Life's* preemption holding to only those state laws which do not fall within the savings clause: "To accept this argument, . . . we would have to ignore the second half of *Pilot Life*, 107 S.Ct. 1555-58, in which the Court made abundantly clear that its preemption holding was equally based on its acceptance of the Solicitor General's view that 'Congress clearly expressed an intent that the civil enforcement provisions of ERISA § 502(a) be the exclusive vehicle for actions asserting improper processing of a claim for benefits.' " (88 Daily Journal D.A.R. at pp. 12664-12665.) The court concluded that it was not possible to read the *Pilot Life* discussion of congressional intent as permitting a state statute like section 790.03, subdivision (h) to supplement the ERISA civil enforcement provisions available to remedy improper claims processing. (*Id.* at

p. 12665.)[5]

Our reading of *Pilot Life* accords with that of the Ninth Circuit in *Kanne*. We are persuaded that section 790.03, subdivision (h) would still be preempted by ERISA even if it were found to be within the scope of the savings clause as a law regulating insurance. This conclusion is compelled by the Supreme Court's discussion of congressional intent, which the court cited as the most significant factor in its determination. (*See Pilot Life Ins. v. Dedeaux, supra*, 107 S.Ct. at p. 1558.)

In *Pilot Life* the Supreme Court held that Congress intended the remedies set forth in ERISA to be the *exclusive* remedies available to ERISA-plan claimants. (*Pilot Life, supra*, 107 S.Ct. at pp. 1555-1557.) However, section 790.03, subdivision (h), as had been

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[5] Other cases have also found preemption. *Lee v. Prudential Ins. Co. of America* (N.D. Cal. 1987) 673 F.Supp. 998 held that although section 790.03, subdivision (h) *does* regulate insurance under the common-sense and McCarran-Ferguson analyses, the statute is nevertheless preempted because ERISA's remedies are exclusive. *Misic v. Building Service Employees Health* (9th Cir. 1986) 789 F.2d 1374 affirmed the dismissal of the plaintiff's state law claims, including a claim under section 790.03, subdivision (h), based on ERISA preemption. *Russell v. Mass. Mut. Life Ins. Co.* (9th Cir. 1983) 722 F.2d 482, reversed on other grounds in *Massachusetts Mut. Life Ins. Co. v. Russell, supra*, 473 U.S. 134, held that the plaintiff's state law claims, including section 790.03, subdivision (h) are preempted by ERISA.

Although some federal courts have determined that section 790.03, subdivision (h) is not preempted by ERISA, those cases were decided prior to *Metropolitan Life* and *Pilot Life* and did not have the benefit of the Supreme Court's guidance on the issue. (*See Eversole v. Metropolitan Life Ins. Co., Inc.* (C.D.Cal. 1980) 500 F.Supp. 1162; *Presti v. Connecticut General Life Ins. Co., Inc.* (N.D.Cal. 1985) 605 F.Supp. 163.)

We are aware that other decisions have been rendered on both sides of the issue presented. Because those decisions are unpublished, they are not discussed here.

interpreted by our decision in *Royal Globe, supra*, 23 Cal.3d 880, provided a private litigant with a cause of action for bad faith settlement practices. (See Part IV, post, p. __' [typed opn. pp. 19-20].) This remedy is not available under ERISA. (*Cf. Massachusetts Mut. Life Ins. Co. v. Russell, supra*, 473 U.S. at pp. 145-148 [private right of action for extracontractual damages is neither expressly nor impliedly available under 29 U.S.C. § 1109, subd. (a)].) Therefore, the remedy available to a private litigant under section 790.03, subdivision (h), conflicts with ERISA's exclusive remedies. This type of conflict was expressly disallowed in *Pilot Life*. (*Pilot Life, supra*, 107 S.Ct. at pp. 1555-1558.) Moreover, in *Pilot Life* the Supreme Court held that Congress's omission of certain remedies was intentional: "The policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA. 'The six carefully integrated civil enforcement provisions found in § 502(a) of the statute as finally enacted . . . provide strong evidence that Congress did *not* intend to authorize other remedies that it simply forgot to incorporate expressly.' " (*Pilot Life, supra*, 107 S.Ct. at p. 1556, quoting *Massachusetts Mut. Life Ins. Co. v. Russell, supra*, 473 U.S. at p. 146, emphasis in original.) We conclude that *Pilot Life's* express holding controls the resolution of this case.[6] *Pilot Life* is directly on point regarding the exclusivity issue, and its conclusion is inescapable.

We find no merit in the argument that if there is any conflict between ERISA remedies and section 790.03,

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[6] In *Pilot Life*, the Supreme Court stated that its analysis regarding the exclusivity of remedies was the most important factor in its determination of preemption. (*Pilot Life, supra*, 107 S.Ct. at p. 1558.)

subdivision (h) remedies, such conflict was created by Congress when it enacted ERISA's preemption clause and saving clause. The argument asserts that the saving clause allows states to regulate insurance and hence to enact conflicting remedies. However, while the saving clause may allow states to enact statutes that regulate the *substantive* terms of insurance policies (*see, Metropolitan Life, supra*, 471 U.S. at pp. 740-744), the clause does not allow states to enact statutes that provide conflicting *procedural remedies* (*see Pilot Life, supra*, 107 S.Ct. at pp. 1555-1558). A contrary rule would undermine ERISA's important policy of promoting uniformity in employee benefit-plan remedies, by creating the potential for conflicting standards of recovery. (*Powell v. Chesapeake & Potomac Telephone Co. of VA.* (4th Cir. 1985) 780 F.2d 419, 422.)

IV

We conclude that ERISA preempts private causes of action under section 790.03, subdivision (h).[7] Of course, our recent decision in *Moradi-Shalal v. Fireman's Fund Ins. Cos., supra*, __ Cal.3d __, prospectively eliminates private causes of action under section 790.03, subdivison (h). Accordingly, our holding of preemption in this case is applicable only to cases which survive *Moradi-Shalal*.

Although our decision in this case prevents Juliano from stating a cause of action for breach of statutory duties under section 790.03, subdivision (h), he nevertheless may amend his complaint to state a claim for ERISA remedies. (*See* 29 U.S.C. § 1132(e)(1) ["State

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[7] We do not decide whether ERISA preempts an action by the Insurance Commissioner to enforce the provisions of the Unfair Practices Act (§ 790 *et seq.*) where such enforcement pertains to a dispute involving an ERISA benefit plan.

courts of competent jurisdiction and district courts of the United States shall have concurrent jurisdiction of actions under subsection (a)(1)(B) of this section"].)

Let a peremptory writ of mandate issue directing the Superior Court of San Diego County to vacate its order denying defendants' motion for judgment on the pleadings as to plaintiff's fifth count for breach of statutory duties under section 790.03, subdivison (h), and to enter a new order consistent with this opinion.

PANELLI, J.

WE CONCUR:

LUCAS, C.J.
ARGUELLES, J.
EAGLESON, J.
KAUFMAN, J.

COPY

COMMERCIAL LIFE INSURANCE COMPANY v. SUPERIOR COURT

S003129

DISSENTING OPINION BY MOSK, J.

I dissent. I strongly disagree not only with the majority's result but also with their reasoning.

I.

With due deference to the United States Supreme Court, I doubt that it gives the bench and bar helpful guidance when it relies on "common sense" as authority for a decision. Nevertheless the High Court has done so in *Pilot Life Ins. Co. v. Dedeaux* (1987) ___ U.S. __ [107 S.Ct. 1549] and the majority herein hold that conclusion to be controlling.

In *Pilot Life*, the court finds a "broad common-sense meaning" (*id.* at p. 1553), a "common-sense view" (*ibid.*), "a common-sense understanding" (*id.* at p. 1554), a "common-sense view" (*ibid.*) and the opinion concludes with a "common-sense understanding" (*id.* at p. 1558).

In reliance on *Pilot Life*, the majority seem to assume that there is some pandemic "common sense" that can guide us in the place of reason and authority. It would indeed be comforting if that were so. But unfortunately it is not: "common sense" is in the eye, or mind, of the beholder.

United States Supreme Court cases have used the term "common sense" in a wide variety of contexts.

Indeed, a cursory count indicates the expression can be found in more than 500 cases over the past 4 decades alone.

For example, the high court has used "common sense" and "subjective" as synonyms. (*See, e.g., United States v. Maine* (1985) 469 U.S. 504, 525.) In other cases, it has equated "common sense" with probability. (*E.g., Basic Inc. v. Levinson* (1988) __ U.S. __, __ [108 S.Ct. 978, 991].) Justice Cardozo wrote of "common-sense accommodation" in *Gully v. First National Bank* (1936) 299 U.S. 109, 117, and in *Monessen Southwestern Ry. Co. v. Morgan* (1988) __ U.S. __, [108 S.Ct. 1837, 1852], reference is made to "common experience or common sense." *Mills v. Maryland* (1988) __ U.S. __, __ [108 S.Ct. 1860, 1875], discusses "a common-sense core of meaning." *United States v. Providence Journal Co.* (1988) __ U.S. __, __ [108 S.Ct. 1502, 1514], discerns a "common sense reading" of a statute, as does *Boos v. Barry* (1988) __ U.S. __, __ [108 S.Ct. 1157, 1162]. *Honig v. Doe* (1988) __ U.S. __, [108 S.Ct. 592, 604], relies on a "common sense proposition." *Carnegie-Mellon University v. Cohill* (1988) __ U.S. __, __ [108 S.Ct. 614, 622], holds a proposition is "confirmed by common sense," and *United Paperworkers Intern. Union v. MISCO, Inc.* (1987) __ U.S. __, __ [108 S.Ct. 364, 374], concludes a judgment is "firmly rooted in common sense." For the ultimate, the court in *Norwest Bank Worthington v. Ahlers* (1988) __ U.S. __, __ [108 S.Ct. 963, 970], found "great common sense." How we are to distinguish between "common sense" and "great common sense" is perplexing.

As a review of the foregoing cases and others like them establishes beyond any dispute, "common sense" is a convenient term. But it is also practically devoid of content.

For instance, in attempting to justify the holding of the court in *Peak v. United States* (1957) 353 U.S. 43, on behalf of the majority Justice Douglas stated, "That seems to us to be the common sense of the matter; and common sense often makes good law." (*Id.* at p. 46.) But Justice Harlan, writing for himself and two others in dissent, drily observed, "Thus is bad law made." (*Id.* at p. 52 [dis. opn. of Harlan, J.].) Can it be said that by disagreeing with the majority on a point of law Justice Harlan and his colleagues were guilty of not using "common sense"? I think not.

In *Roschen v. Ward* (1929) 279 U.S. 337, 339, Justice Holmes declared, "there is no canon against using common sense in construing laws as saying what they obviously mean." Sounds simple. But as Justice Story noted in *Barlow v. United States* (1833) 7 Pet. (32 U.S.) 404, 411, "There is scarcely any law which does not admit of some ingenious doubt." Are the doubters necessarily declining to use "common sense"? I think not.

In *The Kronprinzessin Cecilie* (1917) 244 U.S. 12, Justice Holmes referred to what is apparently a specialized form of "common sense": "Business contracts must be construed with business sense . . . ." (*Id.* at p. 24.) Apparently that did not satisfy the entire court, for Justices Pitney and Clarke dissented. What kind of sense they preferred was not indicated.

Members of the high court have not been altogether unmindful of the problems associated with "common sense." In *Jacksonville Bulk Terminals, Inc. v. International Longshoremen's Association* (1982) 457 U.S. 702, one of the parties argued that a "common sense" interpretation of a statute should be applied. Said Chief Justice Burger in dissent, "the 'common sense' meaning of a term is not controlling when Congress has provided . . . an explicit definition of a labor dispute. 'Common sense' and legislative history ought not to change the

meaning of unambiguous words of a statute." (*Id.* at p. 727 [dis. opn. of Burger, C.J.].)

In *In re Primus* (1978) 436 U.S. 412, then Justice Rehnquist wrote in dissent that the majority's " 'common-sense' distinction [between speech proposing a commercial transaction and other varieties of speech] is subject to manipulation by clever practitioners." (*Id.* at p. 441 [dis. opn. of Rehnquist, J.].)

In short, I believe that the implied invocation of "common sense" as authority for an opinion of this court is insufficient and as such cannot be helpful to the parties in this case or to the bench and bar in future matters. As Justice Rehnquist explained, the term is "subject to manipulation" and therefore lacks substance.

II.

Real party in interest Joseph V. Juliano (hereinafter Juliano) brought the underlying action for damages against petitioners Commercial Life Insurance Company and Automatic Data Processing, Inc. (hereinafter collectively Commercial Life). In his complaint Juliano alleged in substance that Commercial Life had issued a policy of insurance, sponsored by his employer, establishing an employee welfare benefit plan that provided group term life insurance, accidental death and dismemberment insurance, and benefits for major medical expenses, prescription drugs and medicines, and dental care; he was entitled to benefits for treatment of diabetic retinopathy and was so informed by Commercial Life; he received treatment including ophthalmic surgery; at first, Commercial Life paid a small portion of his medical bills, but then wrongfully refused to pay the rest. Juliano asserted, among other causes of action, a claim that Commercial Life had violated its statutory duties under the Unfair

Trade Practices Act (Ins. Code, § 790 *et seq.*), specifically, Insurance Code section 790.03, subdivision (h) (hereinafter section 790.03(h)).

The majority hold that the Employee Retirement Income Security Act of 1974 (hereinafter ERISA) (88 Stats. 829, as amended, 29 U.S.C. § 1001 *et seq.*) preempts section 790.03(h) as relevant here and thereby bars Juliano's claim under that provision. As will appear, they are wrong.

ERISA regulates, among other matters, "employee welfare benefit plans" that, "through the purchase of insurance or otherwise," provide "medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death, or unemployment . . . ." (ERISA § 3(1), 29 U.S.C. § 1002(1).) Within its sphere, ERISA purports to preempt state law. The act states in a preemption clause that its provisions "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan . . . ." (ERISA § 514(a), 29 U.S.C. § 1144(a).) ERISA, however, may not and does not preempt state law in its entirety. As relevant here, the act declares in a saving clause that "nothing in this [statute] shall be construed to exempt or relieve any person from any law of any State which regulates insurance . . . ." (ERISA § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A).)

It is plain that ERISA regulates the plan in which Juliano participated. As stated above, Juliano's employer sponsored a plan providing a variety of insurance coverage and other benefits for its employees.

It is also plain that section 790.03(h) comes within the class of state laws that ERISA purports to preempt. The provision "relate[s] to . . . employee benefit plan[s]" (ERISA § 514(a), 29 U.S.C. § 1144(a)) be defining "unfair claims settlement practices" (Ins. Code, § 790.03, subd. (h)).

But it is plainer still that section 790.03(h) is saved from preemption by the express terms of ERISA: the provision clearly "regulates insurance" (ERISA § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A)). As I read their opinion, the majority do not seriously dispute that section 790.03(h) comes within ERISA's saving clause — nor could they (*see Lee v. Prudential Ins. Co. of America* (N.D.Cal. 1987) 673 F.Supp. 998, 1000-1001).

In spite of the foregoing, the majority hold that section 790.03(h) is not saved from preemption and hence that Juliano's claim under the statutory provision is barred. In support they assert that ERISA has established a civil enforcement scheme that provides exclusive remedies. That may be true. But ERISA's scheme defines remedies *for the violation of rights granted employees under the terms of plans within the coverage of the act and under the act itself.* (*See* ERISA § 502(a), 29 U.S.C. § 1132(a).)[1] By contrast, the

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[1] Section 502(a) of ERISA, codified at 29 United States Code section 1132(a), provides as follows.

"A civil action may be brought —

"(1) by a participant or beneficiary —

"(A) for the relief provided for in subsection (c) of this section [concerning requests to the administrator for information], or

"(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

"(2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 1109 of this title [for breach of fiduciary duty];

"(3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan;

"(4) by the Secretary, or by a participant, or beneficiary for appropriate relief in the case of a violation of 1025(c) of this title

(continued)

Unfair Trade Practices Act, of which section 790.03(h) is a part, has established a civil enforcement scheme that provides remedies *for the breach of duties imposed on insurers under the laws of the State of California.* In a word, the remedies of ERISA may be exclusive in their own sphere, but they do not extend into the sphere occupied by section 790.03(h). (*Cf. Mackey v. Lanier Collections Agency & Service* (1988) __ U.S. __, __ - __ [108 S.Ct. 2182, 2185-2191] [ERISA does not bar a state garnishment action against a covered employee welfare benefit plan: the federal act does not provide an enforcement mechanism for collecting judgments against covered plans and hence does not preempt state law in that area].)

Thus, ERISA does not preempt section 790.03(h), but expressly saves the provision as a law "regulat[ing] insurance." Further, the civil enforcement scheme of the federal statute does not displace the civil enforcement scheme of the state act: the former concerns the rights of employees under covered plans, the latter the duties of insurers under state laws.

III.

There is a growing and ominous trend toward federal preemption of issues that belong within the sphere of control by the individual states. And these inroads into traditional federalism are taking place despite their

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(ftn. continued)
[concerning information to be furnished participants];

"(5) except as otherwise provided in subsection (b) of this section, by the Secretary (A) to enjoin any act or practice which violates any provision of this subchapter, or (B) to obtain other appropriate equitable relief (i) to redress such violation or (ii) to enforce any provision of this subchapter; or

"(6) by the Secretary to collect any civil penalty under subsection (i) of this section [for breach of fiduciary duty]."

inconsistency with pious rhetoric emanating from Washington about returning government to the people at state and local levels.

The first Californian to sit on the United States Supreme Court, Stephen Field, saw the problem clearly as long ago as the period immediately following the Civil War. In *Ex parte Virginia* (1879) 100 U.S. 339, 357, he wrote: "Now, if we look into the Constitution, we shall not find a single word, from its opening to its concluding line, nor in any of the amendments in force before the close of the civil war, nor . . . in those subsequently adopted, which authorizes any interference by Congress with the States in the administration of their governments, and the enforcement of their laws with respect to any matter over which jurisdiction was not surrendered to the United States. The design of its framers was not to destroy the States, but to form a more perfect union between them, and, whilst creating a central government for certain great purposes, to leave to the States in all matters the jurisdiction of which was not surrendered the functions essential to separate and independent existence."

Justice Field took the same position in *Virginia v. Rives* (1879) 100 U.S. 313, 337: "It is difficult to believe that the wise men who sat in the convention which framed the Constitution and advocated its adoption ever contemplated the possibility of a State being required to assert its authority over offenders against its laws in other tribunals than those of its own creation, and least of all in an inferior tribunal of the new government. I do not think I am going too far in asserting that had it been supposed a power so dangerous to the independence of the States, and so calculated to humiliate and degrade them, lurked in any of the provisions of the Constitution, that instrument would never have been adopted."

In the instant case we have a state regulatory statute at issue. In the *Sinking-Fund Cases* (1879) 99 U.S. 700, a state-created corporation was involved. On that subject Justice Field was emphatic: "In a word, the law of the State undertakes to control and manage the corporation, in all particulars required for the service, convenience, and protection of the public; and can there be a doubt in the mind of any one that over its own creations the State has, within its own territory, as against the United States, the superior authority? . . . Under the Constitution the management of local affairs is left chiefly to the States, and it never entered into the conception of its framers that under it the creations of the States could be taken from their control." (*Id.* at pp. 768-769.)

In our case the law regulating insurance was brought into existence by the State. Under these circumstances it could not have been contemplated, within constitutional limitations, that enforcement of this state creation should pass exclusively to Washington.

IV.

In conclusion, I would hold that Juliano's section 790.03(h) cause of action is not barred. Accordingly, I dissent.

MOSK, J.

I CONCUR: BROUSSARD, J.

APPENDIX C

COURT OF APPEAL,
FOURTH APPELLATE DISTRICT
DIVISION ONE
STATE OF CALIFORNIA

FILED
Keenan G. Casady, Clerk
NOV 3 1987
Court of Appeal Fourth District

COMMERCIAL LIFE INSURANCE COMPANY, et al.,
Petitioner,
v.
SUPERIOR COURT, etc.,
COUNTY OF SAN DIEGO,
Respondent.

D006995
(Super. Ct. No. 542103)

JOSEPH V. JULIANO,
Real Party in Interest.

THE COURT:

The petition for writ of mandate has been read and considered by Presiding Justice Kremer and Justices Work and Todd. The petition is denied. (*Goodrich v. General Telephone Co. of Calif. et al.* (Sept. 22, 1987, B020532) [87 Daily Journal D.A.R. 6766].)

/s/ Work
WORK, Acting P.J.

Copies to: All Parties

APPENDIX D

SUPERIOR COURT OF CALIFORNIA,
COUNTY OF SAN DIEGO

Number: 542103 Reporter: Patricia E. Lux
1:30 P.M. ← Court convenes at Clerk: Mary Rademaker
Date: MONDAY, SEPTEMBER 21, 1987
Judge: HON. VINCENT P. Di FIGLIA
Dept.: 35
Plaintiff/Petitioner: JOSEPH V. JULIANO
Attorney for Plaintiff/Petitioner: /s/ TOM LA VOY
Defendant/Respondent: AUTOMATIC DATA PROCESSING, INC.,
Attorney for Defendant/Respondent: /s/ CURTIS METZGER (COMMERCIAL LIFE INSURANCE COMPANY AND AUTOMATIC DATA PROCESSING, INC.)

DEFTS MOTION FOR JUDGMENT ON THE PLEADINGS ON BEHALF OF DEFTS COMMERICAL LIFE INSURANCE COMPANY AND AUTOMATIC DATA PROCESSING, INC AND AGAINST PLTFS JOSEPH V. JULIANO

(NOTE: IRRELEVANT COURT FORM INFORMATION OMITTED.)

OTHER: Motion to Strike granted as to all causes of action except 5 without leave

Form 203 Co. Clk (8/83) Minutes Cal No. 8